Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
P O BOX 24809
HOUSTON TX 77029

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-3101-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please be advised that this patient was in a pre-authorized or Division exempted return –to-work rehabilitation program, therefore preauthorization for the repeat interview was not required."

Amount in Dispute: $710.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor conducted a psychiatric interview with testing along with interpretation of the testing and preparation of the report on 11/18/10. It billed this with codes 90801, 90889, 90887, and 96101." "Codes 90887 and 90889 have a 'B' and nor {sic} not separately payable under Medicare." "The requestor argues codes 90801 and 96101 should be paid because they were provided as a component of a Division exempted return to work rehab program." "Texas Mutual reviewed its claim file and found no billing or documentation of any such program occurring immediately prior, during, or after the disputed date of 11/18/10." "For this reason no payment is due absent preauthorization for the psychiatric interview and testing."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18, 2010	90801, 90889, 90887, 96101	$710.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 21, 2011
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 284 – NO ALLOWANCE WAS RECOMMENDED AS THIS PROCEDURE HAS A MEDICARE STATUS OF 'B' (BUNDLED).
   - 930 – PRE-AUTHORIZATION REQUIRED. REIMBURSEMENT DENIED.

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
2. Did the respondent support denial reasons 97 and 284?
3. Is the requestor entitled to reimbursement?

Findings

1. Per Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code, Section §134.600(p)(7) requires preauthorization of "all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program." Review of the submitted documentation finds no documentation to support that the services were provided as a component of a Division exempted return-to-work rehabilitation program or that the provider obtained preauthorization for the disputed services prior to providing the health care.
2. CPT codes 90889 and 90887 were denied with denial reason codes CAC-97 and 284. These two CPT codes are status B codes and are bundled into the allowance for another service/procedure. The Division finds that the respondent has supported denial reasons CAC-97 and 284. Separate reimbursement is not recommended.
3. Review of the submitted documentation finds that the requestor did not submit documentation to support preauthorization approval was obtained prior to providing the services in dispute in accordance with 28 Texas Administrative Code, Section §134.600. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 19, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.